Report of Rockefeller Foundation

on

PERSONNEL TRAINING REQUIREMENTS

of

THE HEALTH SERVICES ACT

of the

PROVINCE OF MANITOBA

OCTOBER

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SECTION V

PERSONNEL TRAINING REQUIREMENTS
of
THE HEALTH SERVICES ACT

Province of Manitoba

I. INTRODUCTION

In June, 1946, The Honorable Ivan Schultz, Minister of Health and Public Welfare, and the Board of Governors of the University of Manitoba jointly issued an invitation to the International Health Division and the Medical Sciences Division of the Rockefeller Foundation to send a commission to Winnipeg to survey the existing facilities for training health personnel to implement The Health Services Act and to make recommendations for the improvement of these facilities. This invitation was accepted by the responsible officers of the Rockefeller Foundation and the following terms of reference were drawn up by the Minister:

> "Bearing in mind the requirements of personnel for The Manitoba Health Plan and the necessity of implementing the said plan as quickly as possible, to make a survey of the institutions in Manitoba which train personnel utilized in medical and public health and welfare. This will entail:
>
> (a) In regard to medical care, an inquiry into the causes of the inadequacies in the number of physicians in rural Manitoba;
>
> (b) To recommend the measures that should be taken to remedy the situation; and
>
> (c) To outline a pattern of relationship among the institutions training personnel required for public health and welfare, including suggestions for re-organization or strengthening of facilities, syllabi, visual aids, etc., in such a way as to make the training most effective."

The two matters reported of immediate concern for implementation of The Health Services Act (1945) were the scarcity of physicians in rural Manitoba and the need to explore the provision of a community worker to discharge both medical and welfare functions. In addition, as will be noted in the report, there are serious shortages in other categories of personnel required for medical care. While the immediate concern of this report is to suggest steps to solve the immediate problem, it is also desirable that recommendations should be considered for long-term as well as short-term planning; and that the latter should be projected to fit eventually into the long-term plan.

Miss M. E. Tennant, Dr. John B. Grant, Dr. William A. McIntosh, and Dr. Hugh H. Smith, staff members of the International Health Division, spent the period between September 11-21, 1946, in Manitoba to survey institutions devoted to training public health personnel. Outside of Winnipeg visits were made to Dauphin, Brandon, Portage la Prairie, and Stonewall. Dr. Hugh R. Leavell of the Medical Sciences of the Rockefeller Foundation was in Winnipeg from September 11-14 to examine the present status of the Faculty of Medicine of the University of Manitoba. The following report is based upon observations made and information obtained during the course of these brief surveys.

The Health Services Act itself is based very largely on the data contained in "Morbidity Surveys in Municipal Doctor Areas in Manitoba" (1940); "Public Health in Manitoba" (1941); "Hospitals in Manitoba" (1941); "Public Welfare Survey" (1944). These surveys and the annual reports, together with legislation, particularly The Public

Health Act (1940) and The Hospital Aid Act (1940), provide the comprehensive information with respect to requirements for implementing the personnel requirements of The Health Services Act. The extent of implementation of the recommendations arising from these surveys is commendably noted, particularly those stated as "basic" of The Public Health Survey. The availability of this data makes it unnecessary to review the general health and medical situation that otherwise would require reporting and in fact constitute the basis whereby this report is possible with so limited first-hand knowledge of the Province itself. The relative medical and health situation of Manitoba in terms of the other Provinces is admirably set forth in the "Report of the Advisory Committee on Health Insurance"(1942) and particularly the "Health Reference Book for the Dominion-Provincial Conference on Reconstruction" (1945). The survey was materially assisted by briefs submitted by the Advisory Commission—The Health Services Act, the Manitoba Federation of Agriculture and Co-operatives, the Manitoba Wheat Pool, Canadian Legion, Manitoba Association Registered Nurses, and the Women's Institutes of Manitoba. Written briefs were kindly provided by the Advisory Commission, the Manitoba Federation of Agriculture and Co-operatives, and the Women's Institutes of Manitoba. Dr. P. H. McNulty, President of the Manitoba Medical Association, also presented his personal views in respect to medical personnel as he had not had time to present a brief prepared by the Manitoba Medical Association. The main concern was with the scarcity of personnel, not only of physicians but also of nurses.

We are pleased to have the opportunity of making this study in Manitoba because, in our opinion, The Manitoba Health Plan is the most realistic approach in Canada that we have knowledge of, for the provision of better health services. We trust that this Report may help to correct one fundamental defect, which is, that the Plan itself cannot be fully operative unless it is closely integrated with the teaching facilities of the University of Manitoba that are required to prepare the necessary personnel to completely implement the Plan.

After making the study it was evident that the recommendations being suggested to carry out the Terms of Reference would fall into two categories:

(1) Those which should be implemented immediately and completed by the end of the year 1947 and which are:

   (a) the setting-up of the Joint Government-University Planning Committee (as recommended in the first paragraph of section "III—Requirements for Medical Personnel and Their Training")

   (b) The canvassing of the possibility of having the Joint Planning Commission established without delay; such Commission to be representative of the governments and universities of the four western provinces, as mentioned in the first paragraph of section "III—Requirements for Medical Personnel and Their Training";

   (c) The obtaining, with the least possible delay, of a suitable person as Professor of Preventive Medicine and Assistant Dean.

(2) Those for a long-term program, which would naturally follow further study of this Report and the expanding health services by the Joint Government-University Planning Committee.

All of which is respectfully submitted,

Special Commission of Rockefeller Foundation,

JOHN B. GRANT
(Signed on behalf of all members of Special Commission.)

II. THE PROBLEM

The present status of implementation of The Health Services Act may be summarized as follows:

(a) Eleven of the eventual 24 full-time local health units are now operating. Three more have requested the establishment of such units, and it is anticipated the remainder should be established before the end of 1948, provided the necessary personnel can be recruited.

(b) Four diagnostic areas, each consisting of one or more units, are to be established. The Dauphin area is on the point of establishment. Shortages of equipment and personnel are preventing quicker progress.

(c) Seventy-eight medical care districts are anticipated. Eligibility for government assistance is dependent on the prior establishment of local health units and the availability of diagnostic services. Consequently as yet no community is eligible. However, 18 municipal doctor areas are in operation, and 3 more are in process of establishment.

(d) Three hospital areas, known as Areas "A," "B," and "C" are in process of establishment, centering around the urban communities of Winnipeg-St. Boniface, Brandon and Dauphin. These areas will be subdivided into 35 hospital districts, each possessing a district hospital and affiliated medical-nursing units of 6 to 12 beds (doctors' workshops). Three districts are building or renovating their hospitals. Eleven others have approved plans for submission to their electorate. There will eventually be 78 doctors' workshops. None as yet has come into being.

Probably the single greatest deterrent to younger physicians settling in rural Manitoba is the lack of adequate diagnostic facilities such as would be provided through implementation of The Manitoba Health Plan. It is pointed out that whereas the Act makes provision to assist local communities in establishing local health units, diagnostic services, and payment of municipal doctors, the cost for hospitals and workshops is laid entirely upon the local community. In as much as the most important obstacle to implementing the Act is lack of physicians in rural areas, it is important that the establishment of "doctors' workshops" should be undertaken as expeditiously as possible. Such workshops in each instance should be affiliated with district hospitals, particularly for consultation purposes. It is noted that the cost of such workshops is estimated as from $[illegible],000 to $[illegible]0,000. The sequence of establishment of the four main goals of the Act is technically sound, but insofar as practicable, they should be inaugurated as nearly concurrently as possible. This is especially important in respect to solving the problem of attracting physicians to practise in rural areas. The amount of money now available for each medical nursing unit from the fund established by the Wheat Pool might be increased to at least $10,000 if the whole fund is not earmarked solely towards this end. To date six districts have voted under The Health Services Act on provision of hospital facilities for their district and in all instances the vote has been favourable. This means the erection of four modern district hospitals, together with the establishment of 12 new medical-nursing units, or "doctors' workshops."

Successful public health planning and implementation depends on economic practicability. One notes with interest that in spite of an overall *per capita* provincial budget lower than at least three of the provinces, Manitoba's total expenditure for health purposes is higher than any province, and, as was brought out in the Public Health Survey (1941), is higher than the three states with which Manitoba is compared. However, one's attention is called to the fact that the total provincial budget for 1946 is approximately $15,000,000 exclusive of capital charges. The problem of personnel relates to education, where one finds that the total budget is approxinately $3,200,000, which includes a grant to the University of Manitoba of $423,300. The total expenditure of the University of Manitoba for the year ending April 30th, 1946, which includes the above mentioned government grant, as shown by the Annual Report of the Comptroller General for Manitoba, is $1,207,563, which is exclusive of the net result of operating the Book Store, Cafeteria, etc. Included in the above costs are all the necessary expenditures

to operate the Faculty of Medicine of the University of Manitoba, which amounted to approximately $120,000 for the fiscal year 1945-46.

The essential administration of any public health and welfare service depends on the fulfilment of three primary principles. It is important to determine the extent that these principles are complied with in Manitoba.

1. The Health Services Act fulfills *"The first principle of good administration requires that when a special function is to be undertaken, it shall be undertaken by one governing body for the whole community needing the service and not for different sections of the community by several governing bodies."*(1) However, for historical reasons of evolution there is minor infringement of this principle in the set-up of organization of the Department of Health and Public Welfare. Tuberculosis control has not been transferred as yet from the Sanatorium Board. Hospitals would be supervised both by the Bureau of Extension Health Services under the Division of Health Services and by the Bureau of Mental Institutions under the Division of Psychiatric Service. For the present, circumstances require that the Section of Maternal and Child Hygiene and aspects of Public Health Nursing remain under the Preventive Medical Services, instead of being amalgamated in Extension Health Services. The implementation of The Health Services Act should result in two developments, first, that the family rather than the individual becomes the unit of practice for the practitioner, and that preventive services for the individual be gradually incorporated into the routine responsibilities of the general practitioner, as soon as education and other circumstances prepare him to undertake this step adequately.

Attention is drawn to an apparent anomaly in the instance of one of the municipal physicians visited. Prior to the establishment of the local health unit, the municipal physician had been discharging preventive functions with respect to immunization and physical examination of school children, for which he was remunerated. With the establishment of the local health unit, the municipal physician was relieved of these preventive functions, which must be regarded as a retrograde step except for the realities of the situation. These are that the municipal physician serves a community with a population of 3,000, from which it would seem that preventive and curative functions cannot be integrated where the patient-physician ratio is above a certain standard. Presumably such a standard would be a population of 1,500, as laid down in the Second Interim Revision by the Advisory Commission of *"Recommendation of the Joint Committee for Basic Principles of the contract with Municipalities and Practicing Physician."* It is consequently recommended that in such Areas as "B," where 13 of the present 18 municipal doctor units in the Province are now operating, every effort should be made to integrate preventive with curative. Eventually this would permit of health unit doctors to assume larger jurisdictions than their present populations of 15,000 to 25,000 people.

2. The implementation of the Act will eventually provide compliance with the second principle. *"Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical service must be brought together in close co-ordination. They must likewise be both brought within the sphere of the general practitioner, whose duties should embrace the work of communal as well as individual medicine."*(2)

3. Manitoba has as yet only partially envisaged compliance with the third most important principle as regards organization.

"The domiciliary service of a given district would be based on a primary health center —an institution equipped for services of curative and preventive medicine to be conducted by the general practitioners of that district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists. Primary health centers would vary in their size and complexity according to local needs, and as to their situation in town or country, but they would for the most part be staffed by the general practitioners of their

(1) Ministry of Reconstruction (England) 1919.
(2) Interim Report on The Future Provision of Medical and Allied Services—Ministry of Health (England) 1920.

district the patients retaining the services of their own doctors. A group of primary health centers in turn should be brought into relation with a teaching hospital having a medical school. The first step in the experimentation and demonstration of progress in new forms of medical service is its establishment by the teaching hospitals.

In those parts of the country where it is geographically possible, it is desirable that every secondary health center should be brought into relationships with a teaching hospital. The academic influence and the spirit of inquiry and progress associated with a teaching hospital would permeate the system of such a medical school. The teaching hospital could initiate and guide collective investigations in which the health centers and doctors connected with them could play an important part. Post-graduate study at teaching hospitals should be further organized and extended. It should now include special training for the communal health services. To this end model communal health clinics would need to be established in connection with the teaching hospitals where doctors could receive the training necessary to enable them efficiently to staff communal clinics throughout the country.

"It is vital to the success of any scheme of health service that there should be unity of idea and purpose, and complete and reciprocal communication among the associated teaching hospitals, secondary health centers, primary health centers, and the domiciliary services, whether the centers are situated in town or country. Existing methods of health administration, untoward as they do considerable diversity of responsibility, would not secure this essential condition, and there will be need for a new type of health authority to bring about unity of local control for all health services, curative and preventive."[3]

This relationship and significant responsibility of the medical teaching center is amplified further in this report. Good medical care requires resolution of three separate complementary factors:

(i) Any economic barrier to good medical care must be removed. The prepayment proposals of the Act solve this problem.

(ii) Medical personnel must be competent and provided with adequate tools. While the Act provides for diagnostic facilities, its provision for graduate and refresher courses is limited to making opportunity available for such courses without any reference to their content. This point is developed later in the report.

(iii) The third organizational factor requires efficient distribution of medical personnel and facilities. The Act has envisaged this quantitatively but not qualitatively. This point is also developed later.

An attempt was made to analyse the existing personnel situation in various categories of medical workers, together with the availability of various types of institutions. Studies have recently been made particularly in the English-speaking countries, to determine the number and categories of medical personnel required to provide a satisfactory health service. The mean was taken of the figures provided through the American Hospital Association, the United States Public Health Service, the Regional Hospital Surveys in Great Britain as well as studies of the Australian Social Security Board. It was hoped this would provide a yardstick to measure the situation in Manitoba. Unfortunately, it proved difficult to secure ready accurate information, and in certain categories the available data were so meager as to prevent obtaining any worth while information, except of a negative nature. The least inaccurate figures related to the physicians of the Province. The analysis of this is presented in the following table. The information with respect to institutions and other categories of medical workers is reported in the Appendices. The chief value of the latter is in providing a rough approximation of the personnel situation insofar as it is repeatable. The unreliability of the data is indicated by the fact of different figures being reported under the same category.

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(3) Ibid.

Table I shows that the problem of maldistribution is as important as any numerical shortage.

TABLE I
DISTRIBUTION—MEDICAL PERSONNEL IN MANITOBA 1946

Recommendation of one	Greater Winnipeg Estimated 1945 population 320,000				Balance of Province Estimated 1945 population 430,000				Total Province Estimated 1945 population 750,000			
	Now Practising				Now Practising				Now Practising			
	Number	Population ratio	Required number	Shortage	Number	Population ratio	Required number	Shortage	Number	Population ratio	Required number	Shortage
General Practitioner to 1,500 population	213	1,468	213	5*	157	2,739	287	130	375	2,000	500	125
Surgeon to 10,000 population	25	12,800	32	7	14	30,714	43	29	39	19,231	75	36
Eye, Ear, Nose and Throat to 15,000 population	14	22,857	21	7	3	143,333	29	26	17	44,118	50	33
Internist to 30,000 population	17	18,824	11	6*	11	39,091	14	3	28	26,786	25	3*
Gynaecologist and Obstetrician to 20,000 population	15	21,333	16	1	1	430,000	22	21	16	46,875	38	22
Pediatrician to 30,000 population	10	32,000	11	1			14	14	10	75,000	25	15
Roentgenologist to 80,000 population	10	32,000	5	5*	1	430,000	7	6	11	68,182	12	1
Pathologist to 100,000 population	2	160,000	3	1	1	430,000	4	3	3	250,000	7	4
Urologist (USPHS) to 65,000 population	6	53,333	5	1*	1	430,000	7	6	7	107,143	12	5
Orthopedist (USPHS)** to 100,000 population	10	32,000	3	7*			4	4	10	75,000	7	3*
Dermatologist (USPHS) to 100,000 population	3	106,667	3				4	4	3	250,000	7	4
Psychiatrist (USPHS) to 100,000 population	(1) 4	80,000	3	1*	(2) 15	28,667	4	11*	19	39,474	7	12*

*Over required number
**USPHS—United States Public Health Services.

(1) Includes two Psychiatrists in institutional work who are not available for private practice

(2) Includes fifteen Psychiatrists in institutional work who are not available for private practice

III. REQUIREMENTS FOR MEDICAL PERSONNEL AND THEIR TRAINING

Proposals for the training of personnel to implement The Health Services Act are based on certain fundamental considerations.

First, [illegible] population which can support and be served efficiently by each category of training institution. [illegible] known that medical and dental institutions graduating annually [illegible] are sufficient for the replacement needs of [illegible] populations as obtain in the three Prairie Prov[illegible]ablish training institutions of all [illegible] institutions have already been established, it may be difficult to secure co-o[illegible] Planning [illegible] The report [illegible] Manitoba [illegible]

[illegible] the second general consideration [illegible] hospitals and their [illegible] training and research [illegible] The report is based [illegible] health services is a properly planned and carefully conducted medi[illegible] of physicians and nurses but also [illegible] dietitians, physiotherapists, occupational [illegible] social workers, laboratory and X-ray technicians [illegible] The medical school hospital should not be the only [illegible] institutions would be twofold. A hospital possessing teac[illegible] more effectively. The [illegible] of physicians and other [illegible] practice in rural [illegible] Manitoba and its Faculty of Medicine [illegible]

The Faculty of Medicine [illegible] Manitoba would have associated with it [illegible] Winnipeg [illegible] the hospitals in [illegible] for teaching. Local Health [illegible] with the Faculty of Medicine [illegible] field of responsibility, but the activities of the several constitutent institutions should be so related that they function as an entity in the fields of training and research.

[illegible] the third general consideration in implementing the personnel requirements of The Health Services Act is that the curriculum of the Faculty of Medicine of the University of Manitoba should be reviewed in terms of training the basic doctor to meet the job analysis requirements of the municipal doctor.

(c) The first step toward re-orientation would be the strengthening of the Department of Social and Preventive Medicine through the appointment of a full-time head who should possess both clinical and public health qualifications.

This professor because of his community liaison responsibilities should be appointed Assistant Dean together with a concurrent appointment from the Department of Health and Public Welfare. The Assistant Dean's responsibilities would include the training and research functions of the extramural constituent institutions and health centres and to make necessary arrangements for various types of post graduate and continuation training. Naturally such wide responsibilities would require that he be provided with one or more full time assistants to be in charge of the training facilities in such health areas as would be designated for field training.

(d) The second immediate step is that a full-time head be appointed for each of the three major Clinical Departments and of Roentgenology of the Faculty of Medicine of the University.

Implementation of The Health Services Act will require clinical consultation services. The three heads of Clinical Departments and the professors of Pathology and Roentgenology should serve concurrently as consultants to the Bureau of Extension Health Services. It must be borne in mind however that any re-orientation in the system of medical education to meet the requirements of The Health Services Act cannot become effective quicker than the change of outlook on the part of teachers and the development of new teaching methods. However the time lag between the initiation of the plan for curriculum reform and its fruition could be materially shortened through special steps under section 36 of the said Act to provide promising young practitioners with a means of fitting themselves for teaching positions.

FOURTH a fourth general consideration is that the Faculty of Medicine of the University of Manitoba has been doing a good job of training students despite its limited facilities and a most inadequate budget. But the desired re-orientation and the implementation of The Health Services Act requires considerably increased support not only to the medical teaching center itself but to the constituent extramural institutions. However such funds should be channelled through the Faculty of Medicine rather than being made available to the institutions or centers directly. The resolution adopted in 1945 by the Manitoba Medical Association should be implemented to study the problem of providing more adequate teaching clinical material in Winnipeg itself. The two proposed constituent hospitals should be surveyed with respect to physical facilities and standards of personnel required for the training of interns and to provide residencies for certification training in designated specialties. Each of the two institutions should have certified specialists in at least the three major clinical fields in addition to a qualified pathologist and a radiologist. Consequently the Joint Government University Planning Committee should survey the two institutions in terms of making them acceptable for training of health personnel, particularly of interns and residents. The present tuition fee of the Faculty of Medicine of the University of Manitoba fails markedly in meeting the cost of training medical students. The Joint Government University Planning Committee should explore the actual costs and recommend raising the tuition commensurate with the actual costs together with a proposal whereby students willing to enter a government service would have at least part of their tuition defrayed by bursaries.

The general practitioner, municipal doctor, is the foundation stone of any health service. Consequently the foregoing general considerations are directed toward the training of the basic doctor without however prejudicing the importance of other categories of medical personnel. The medical teaching center should be concerned with, if not responsible for the training of medical personnel other than doctors. Acceptance of the foregoing general considerations permits exploring the situation as regards training for all categories of personnel, of which the first is the physician.

1. THE FACULTY OF MEDICINE OF THE UNIVERSITY OF MANITOBA

The survey revealed that the three principal personnel questions involved in the present situation were

(1) Why is it that graduates of the school do not stay in Manitoba to a greater extent than they do?

(2) Why is it that doctors do not want to practise in rural Manitoba?

(3) Can the Medical School take additional students and maintain its standards?

(1) The general situation as to physician requirements has been indicated in the foregoing table. The immediate problem is one of distribution of physicians, rather than number. The dean's office reported that as of July 1, 1946, there were 481 physicians registered in Greater Winnipeg, with a population of 320,000, as compared with 215 in rural Manitoba with a population of 430,000. There appears to be some discrepancy between the Second Interim Revision of Recommendation of the Advisory Commission recommending one municipal physician for each 1,500 population that would imply 287 municipal doctors with the statement made that eventually there are to be 78 medical care districts. The 157 general practitioners in rural Manitoba would have to be increased by 130 to meet the standard set of one physician to 1,500 population. It was stated during the survey that the annual replacement requirements would be 30 physicians. The following table of applications to the first year of medicine from Manitoba, exclusive of Greater Winnipeg, indicates that annual recruitment from the rural area might be stimulated to supply replacement needs, were all to return to their own communities.

YEAR	RECEIVED	ACCEPTED
1936	16	12
1937	28	17
1938	24	15
1946	43	12

(2) Probably no one answer to the first two questions can be given. Certainly the answer does not lie wholly in increasing the number of students admitted to the Faculty of Medicine of the University. One was impressed by the emphasis given to the rural problem of lack of doctors in the hearings of the briefs submitted, particularly by members of the Advisory Commission under The Health Services Act, and of the Manitoba Wheat Pool. The first point brought out was the absence of amenities, of which the most important has been the lack of "doctors' workshops." Steps have been recommended in the Introduction to solve this problem. Arrangements for post-graduate training, both intramural and on an extension service basis, would also be an important step. This would require arrangements to provide *locum tenens* so that doctors taking post graduate training could have their local practices covered. Proper housing, schools, recreational and religious facilities, as well as improved communications, are factors which cannot be overemphasized. There should be a planned, long-term recruitment program. Preparatory schools and colleges serving the rural areas should be contacted and an educational program undertaken to interest students in entering the medical profession. The Joint Government University Planning Committee should have a voice in the management of any bursaries which may be provided. Organized health clerkships and preceptorships for medical students in rural areas, as well as internships in constituent hospitals, would serve to give them a picture of the conditions of rural practice and perhaps convince them that the situation is not so difficult as they might otherwise have anticipated. Since a good many of the medical students marry nurses, it might be advantageous to acquaint the nurses with the problems of rural Manitoba, so that they might be more interested to go there as wives of rural physicians. Every country is confronted more or less with the problem of scarcity of personnel for rural areas. The recent British Health Services Act is providing a sliding basic salary scale, which increases with the lack of amenities. The Soviet Union offers higher salaries

in rural, as compared with urban, together with other attractions. The Australian Service now being inaugurated staffs rural areas with junior general practitioners for limited periods and opportunity for advancement to larger centers.

5. The third of the above questions would appear to beg the question unless the required amenities noted above are provided. So long as Manitoba has to graduate three students in order to retain one with the majority who remain in Manitoba settling in Winnipeg, the problem does not seem primarily one of expanding the facilities of the Faculty of Medicine of the University. In fact, it might be cheaper to provide doctors' workshops than to enlarge the medical school. The school could increase its enrollment by 20 to 25% without too seriously impairing its standards provided sufficient funds are available to employ additional instructors and to take care of the necessary physical facilities. It must be remembered that the present budget is so low that the amount of funds necessary to increase enrollment will be greater than proportionately might be estimated on the basis of present enrollment. An increase of 50%, would seriously overtax the facilities of the School. The following specific changes would be necessary:

(i) The laboratories would have to be rearranged.

(ii) Additional preclinical instructors would have to be provided, and these cannot be found on short notice.

(iii) Additional cadavers would have to be made available for Anatomy.

(iv) Additional clinical material would have to be made available through providing general practitioner preceptorships, using cases paid for by Government funds and developing the regional or area hospitals as constituent teaching institutions.

In any event, any increase in student enrollment made at the present time with the existing facilities should be undertaken as a temporary measure, and, in our opinion, this increase should not be more than 20% to 25%.

Major proposals have already been made with respect to the development of the Faculty of Medicine of the University as the base of a medical teaching center. Further detailed suggestions would be that the present teaching in the specialties now making up most of the clinical teaching should be redefined to emphasize the diagnosis and treatment of conditions which the general practitioner is capable of handling in his practice. Specialists should be developed only during the post graduate training period. The teaching of social and preventive medicine which now is given over each of the four undergraduate years should be extended to the interne year. At least 4 weeks of the 1 year of the medical curriculum should be available for social and preventive medicine. The budget of this department should be from 3% to 5% of the total Faculty of Medicine of the University operating budget. Insofar as possible preventive medicine teaching should be done by the clinical departments as a part and parcel of the regular teaching of clinical medicine. This would entail co-ordination with much strengthened medical social service departments, in order that the desired emphasis could be given on the social and economic aspects of medical care. Medical care economics should also be a part of the curriculum, with full discussion of schemes for meeting the problem of medical care. Inasmuch as practitioners in rural areas will be in very close contact with regional or area hospitals, there should be discussion of the major problems of hospital administration. Public Health, as such, should be treated as a special subject with full recognition that training for a public health career is a post graduate undertaking. Health education needs to be stressed as a continuous responsibility and opportunity of practising physicians.

It is assumed that the modern teaching center would assure facilities for the qualification of each of the types of specialists listed in the table given earlier. Facilities for training of brain, thoracic surgeons, etc., might or might not conveniently be provided.

Training of public health officers is a post graduate undertaking. The Province now has 11 qualified DPH* officers. It is envisaged that under the present organization of

*Diploma in Public Health (Post Graduate Course)

The Health Services Act some eventual total of 36 full-time health officers will be required. This small number implies that it might not even be deemed advisable for all of the four western provinces to undertake jointly post-graduate public health training. It should be pointed out, however, that in almost all instances opportunities for post graduate training in public health have been provided by fellowship grants from private foundations. In the opinion of the Survey Commission the time has come for government to take over that important responsibility and it is suggested that the Provincial authorities make strong representations to the Dominion Government to provide such fellowships on an adequate scale. In fact, such representations for determination of grants and aids should extend to the several fields of health services such as provision of local health units, diagnostic services, research. This principle of a federal aid to states and provinces is becoming increasingly acknowledged not only throughout the Commonwealth, but in the United States, and is an almost essential measure to assure the required standards of health services to the people of the country in question.

2. COMMUNITY PRACTICE FIELDS.

The designation of the Act as the "Health Services" rather than "Medical Services" Act implies the emphasis on prevention in addition to diagnosis and therapy of disease. Medical trainees of all categories can be educated in prevention only through adequate provision of facilities for training themselves. This principle has long been accepted in the provision of teaching hospitals for training in diagnosis and therapy. The practice of prevention is found, however, only in the community itself. The provision of community practice fields is essential but is relatively so new a trend that this section of the report goes into considerable detail to suggest possible opportunities in providing field teaching facilities in order that practical experience may complement the intramural courses for personal service and in service training of health trainees and medical students.

The following enumeration of a few of these facilities will suffice to indicate the types of field opportunities which await exploitation:

(i) medical preceptorships with outstanding private practitioners of medicine and with leading municipal doctors practising in rural areas of the province,

(ii) medical and nursing apprenticeships in medical-nursing unit district centers, opportunities which will become more and more available as these doctor-nurse "workshops" are established in the province;

(iii) medical internships and residencies in the larger hospitals outside Winnipeg, such hospitals to be affiliated with the Faculty of Medicine, University of Manitoba, as auxiliary training and teaching institutions,

(iv) medical and public health traineeships with the City Health Department of Winnipeg, to provide experience in public health administration, children's services, dental services, public health nursing services, sanitary engineering services, food and dairy supervisory services, acute communicable disease control, venereal disease services, and other services carried out by this progressive City Health Department),

(v) medical and public health traineeships with selected full time rural local health units, in order to provide experiences in the several health services of those units as adapted to rural and small community conditions in Manitoba,

(vi) assigneeships or apprenticeships with the Provincial Department of Health and Public Welfare

(a) for the purpose of acquainting public health trainees and medical students with the organization and program carried out by this Department in the interest of effecting better future administrative inter-relationships; and

(b) to provide special training as may be afforded by the several Divisions of this Department for selected trainees and students, depending upon their interests and requirements, and

(vii) assignments in the interest of effecting better administrative co-operation and for providing apprenticeships for medical and other students with

(a) such institutions as

Tuberculosis Sanatoria, and
Psychiatric Hospitals, and
their corresponding field clinics, such as
tuberculosis diagnostic clinics, and
child guidance clinics.

(b) other organizations and institutions operating in Manitoba, which might provide practical field training experiences, such as

(aa) The Victorian Order of Nurses, with respect to the training of basic and graduate public health nurses;

(bb) suitable hospital laboratories and X Ray departments, with respect to the training of laboratory and X-Ray technicians,

(cc) The Manitoba Hospital Services Association, as well as The Manitoba Medical Services, to facilitate the students' needs in becoming acquainted with the practical application of the principles of medical economics, and

(dd) selected hospitals, for the purpose of giving students insight into the administrative practices of these institutions. (Such opportunities as these now available for acquiring field experience may be expected to be markedly expanded as the provisions of The Health Service Act are put into effect, and as the City of Winnipeg's Public Health Program continues to unfold.)

Administrative proposals, as set forth below, may be conveniently dealt with under the following sub-headings

(a) Organizational considerations,
(b) The Selkirk and Red River Rural Practice Fields,
(c) The Winnipeg-University Area Practice Field, and
(d) The Health Services Unit Area Practice Field.

(a) *Organizational Considerations.*

The recommendation has already been made for a full-time Professor of Social and Preventive Medicine, with such assistants as may be required. It is also recommended

That the Director of Extension Health Services of the Department of Health and Public Welfare, and the Deputy Medical Officer of Health, of the City of Winnipeg Health Department, be given suitable appointments in the Department of Social and Preventive Medicine of the Faculty of Medicine, University of Manitoba, without pay, but entitled to the prerogatives accompanying such a position.

The faculty members of the Department, under the direction of the Professor would then constitute a Committee to Develop Community Practice Fields as opportunity permits. Seven categories have been suggested. Of these the following could be established in the immediate future

(aa) medical preceptorships,
(bb) medical internships and later residencies in hospitals outside of Winnipeg,
(cc) medical and public health trainees with the City of Winnipeg Health Department;

(dd) medical and public health trainees in the proposed Selkirk-Red River rural local health units,

(ee) apprenticeships with the Provincial Department of Health and Public Welfare, and

(ff) apprenticeships with special institutions, particularly psychiatric and tuberculosis.

The Committee to Develop Community Practice Fields would be responsible to see that the several constituent institutions should be so related that they function as an entity in training, while assuring that the several governing bodies (boards of directors, government departments, etc.,. should each retain full authority in their own normal field of responsibility The mechanism of collaboration is

(i) the local governing body acknowledges the benefit of University control of community field training facilities, and accordingly

(ii) agrees to accept the need for the University's approval in the appointments to the staff to supervise the community or institution in question.

To assure the competency of personnel and investigational facilities, the University must be responsible for any salaries and expenses above those provided by the local governing body Such mechanism for University Community collaboration has been successfully provided in various parts of the world, including Great Britain, New Zealand, the United States, and Toronto.

(b) *The Selkirk-Red River Rural Practice Fields.*

This project area referred to is one in which the plans have been completed by the Department of Health and Public Welfare, with the assistance of the W K Kellogg Foundation This plan should now be revised in terms of the foregoing organizational suggestions to provide affiliation with the University through its Department of Social and Preventive Medicine. Two proposals may be considered

First, that the University should nominate an Associate Professor of Social and Preventive Medicine for government appointment as Director of the two local health units.

Second, because of the teaching and research responsibilities to be assigned to the staff, the salary scales should be reviewed from the standpoint of assuring competent and mature individuals

Any required supplementation above the present scale would be the responsibility of the Department of Social and Preventive Medicine.

(c) *The Winnipeg-University Area Practice Field.*

Urban administrative conditions are so different from rural that as soon as practicable it is recommended

That an Urban Community Practice Field comparable in training function and University relationship to the Rural should be made available

It is assumed that eventually, as has been the case in the growth of cities elsewhere, a metropolitan health administration will evolve The question is raised whether the present is not the appropriate time to give consideration to such a step in Winnipeg. Such a metropolitan health service would provide decentralized units In view of such an anticipated development, it would seem appropriate to formulate plans for the first of such units in the area in which the Medical Teaching Center is located The scheme should in the first instance originate with the Medical Health Officer of Winnipeg. It should be borne in mind that in the city legal provision has not been made for interrelating local health services, diagnostic services, medical services, and hospitals, as elsewhere in the Province The Committee to Develop Community Practice Fields constituted by the Department of Social and Preventive Medicine should be responsible to

advise the Medical Health Officer to so relate these services to function as a single entity in the training of health trainees. Full advantage should be taken of the ready availability of such a decentralized health unit to serve as a research field to develop public health clinic services for establishing preventive routines concerned with effective professional supervision of presumably well persons.

(d) *A Health Service Unit-Area Practice Field*

A long term proposal is that at such time as may be expedient, one of the three major hospital areas into which the Province has been divided for purposes of hospital administration be reorganized as a unified health services unit and regional practice field.

What is involved in this proposal is in a word the decentralization of the Provincial Department of Health and Public Welfare as relates to the services provided for in The Health Services Act. While the details of the plan of reorganization effecting this proposed change might best be left to the co-ordinating staff on community practice fields, an outline of the general features of the proposed plan is included here for purpose of clarification of the concept embodied in the proposal. Accordingly the broad features of the plan may be enumerated as follows:

1) The Medical Nursing Unit Districts would provide for public health services, as well as for curative medical services, to the fullest extent possible.

2) The Hospital Districts would be organized under a medical director as a Health Services District, perhaps embodying two or more hospital districts, to administer collectively health services proper, diagnostic services, medical services, as well as hospitalization services, and such jurisdictions would include for the purposes of administration the smaller Medical Nursing Unit Districts associated with the district hospital, or the district hospitals, if more than one are included,

3) The over all regional Hospital Area would be re-organized as a Medical Services Unit Area, comprising the several hospital districts in the Area, but organized under the plan here proposed as a Health Services District.

The administrative staff of the regional Health Services Unit Area would consist of a medical director, supervising nurse, sanitary engineer and such other employees as may be required to effect proper administration and provide adequate supplemental specialized services for the entire area. The several district medical directors would serve as deputies of the regional medical director and the supervisors and specialists working on the staff of the regional Medical Services Unit would operate through official channels in contributing their several services throughout the jurisdiction of the regional Health Services Unit Area. Instead of having separate advisory bodies for hospital and health services within this regional jurisdiction it is suggested that there be one regional Health Services Board and a corresponding board for each health services district, to be associated respectively with the medical director of the Health Services Unit Area and each of the local medical directors of health services districts. Furthermore, the overall board would provide for representation of each of the health services district boards, in the interest of interlocking the services of the district boards with those of the regional board.

The principal advantages of such a plan of organization would be to effect organizational integration with respect to local health services, diagnostic services, medical care and hospitalization services, and it is probable that the overhead administrative costs of the present plan of organization could be appreciably reduced by this proposed plan or organization, especially as relates to the reduction in the number of local medical health officers who would be required. The funds saved in overhead administrative costs could, of course, be expended to advantage in the employment of additional direct service workers, such as municipal doctors and public health nurses.

Which one of the three major Hospital Areas should be selected as the Health Services Unit Area Practice Field, the auxiliary personnel who may be required to supplement the basic health staff in order to provide for the functioning of this Health Services Unit Area as a practice field for pre-service and in-service medical and public health students and trainees, how best to effect co-operation of all concerned in developing the details of the scheme for the organization and functioning of this proposed Health Services Unit Area, the formulation of legislation which would be needed to effect the re-organization recommended here for consideration, these, as well as all other administrative matters concerned in its realization, can best be left to the discretion of the co-ordinating staff on community practice fields.

3. DENTISTRY

Appendix 1 shows the Province is much below standard in the number of dentists required for adequate dental care. Reference has already been made to the expensiveness of dental education and the recommendation is that the solution of this problem should not be undertaken by the Province alone, but in co-operation with other Provinces. Exploration by the Joint Government-University Planning Committee should also include the training of oral hygienists and dental technicians. It may be necessary to provide loan funds, as in the case of medical students.

4. NURSING

Manitoba has a total bed complement of 8,806. For the specialties there is the following distribution: For obstetrics, 544 beds, for children, 251 beds, for tuberculosis, 1,084 beds, for mental, 3,078, for chronics, 713, and for infectious diseases, 340.

The Manitoba Association of Registered Nurses reports that there are 2,000 registered nurses in the Province, 300 student nurses were graduated this year and 333 were graduated in 1945. The following information was also given:

General duty nurses	666 with a shortage of	267
Head nurses	159 with a shortage of	18
Supervisors	112 with a shortage of	19
Instructors	24 with a shortage of	9
Public health nurses, rural	70 with a shortage of	55
Public health nurses, urban	75 with a shortage of	31

Total—1,106 nurses, and a shortage of 399.

No record was given of the remaining 894 nurses in the Province. Some of those are no doubt married and not working and others are private duty nurses, but it is not likely that they would account for such a large number. It would be of interest to determine the status of the 894 registered nurses in Manitoba whose professional activities are not accounted for in the above list.

Manitoba has ten hospital schools of nursing which graduated this year 300 students. The two largest hospital schools are Winnipeg General Hospital (which graduated one-third of the students) and St. Boniface. Each of these institutions has over 500 beds and is used as a teaching hospital by the Faculty of Medicine of the University. The remaining eight hospital schools are in institutions each having less than 100 beds. Students from all of the schools provide nursing care of patients. Some hospitals have no general duty nurses, whereas others have only a few. Because of nursing service demands there is little correlation of theory and practice. Basic sciences are generally taught by nurses who themselves have limited preparation in anatomy, physiology, materia medica and microbiology. One school only has a full-time public health nurse on its staff. The two largest schools provide one week of observation for student nurses in the public health field. No school of nursing includes tuberculosis nursing experience for student nurses, in spite of the fact that tuberculosis is an important health problem in Manitoba. Only one school of nursing in the Province gives psychiatric nursing experience and in that one only six weeks is provided. The School of Nursing at the Hospital for Mental Diseases at Brandon

is affiliated with the School of Nursing at the Winnipeg General Hospital and supplies a course covering a two years' training period in each school which after four consecutive years' training leads to a Diploma in Mental Nursing and a Diploma in General Nursing. Nurses' school experience is not permitted for students in any school of nursing. The basic curriculum is therefore emphasized on the curative aspect of nursing.

Upon finishing these courses of training the nursing graduate nurse is prepared only for hospital nursing. If she is interested in public health she must spend an academic year at one of the Universities offering a general course in public health nursing. University of Manitoba since 1961 offers courses in public health nursing, teaching and supervision in schools of nursing and school of nursing administration. University credit is not given for the nursing curricula. There are two graduate nurses teaching these courses, and they operate on a small budget of around $6,000 which covers salaries primarily. Public health field practice is permitted by the City and Provincial Health Departments and the Victorian Order of Nurses under various charges. There is no true correlation between theory and practice and the amount of practice received in each agency places separately and one student may get all three agencies. Winnipeg General and St. Boniface Hospitals are used for the basic hospital training of graduate nurses.

In viewing the need for nurses it was felt that Miss Fisher might expand on the suggestions in "The Preparation for Professional Nursing" — Miss Fisher, Canadian Nurse, September 1966. This is to meet nursing needs through training three levels of workers: the professional nurse, the skilled nurse, who is also familiar with the general practice of a complete health service, and the practical nurse.

The basic curriculum of a University school leading to a degree would combine cultural materials with the professional courses and cover a minimum of four years. The aim would be to prepare a nursing woman for community nursing service. That is the personal and social aspects of medicine and nursing would be interwoven with the curriculum throughout so that upon completion of studies the student would be prepared as a staff member in community nursing. The social aspects of medicine and nursing should include social principles of social case work so that in the rural area the staff member would be able to handle the welfare problems under qualified social worker supervision. The meeting of the western provinces requirements for university trained professional nurses is one that the Joint Planning Committee should explore.

An undergraduate university school would have to pick and choose the practice fields — those in public health and welfare areas which would be necessary to give basic preparation for its students. Nursing experience would be given in medicine, communicable diseases, including tuberculosis and mental hygiene, surgery, obstetrics, child care, nursery school and pediatrics, psychiatry, public health nursing, hygiene and nutrition, nursing and chart therapy, housekeeping, sanitation and social welfare. Theoretical instruction includes instruction in the biological and physical sciences, social sciences, humanities and medical sciences.

Fortunately there is not a need to establish an excellent university school of nursing at the University of Toronto and its Calendar for 1966-67 gives a good description of its courses, both basic and post-graduate.

In view of the fact Manitoba has a medical school and plans are under way for a teaching institute centre it is only logical to envisage a school of nursing in the University group. But the cost of such an undertaking is severe and doubtful whether Manitoba could afford it. However it seems the school could be developed as a part project with minor assistance. Fortunately the costs for a university school of nursing are not yet published. During the course of the next few months the Division of Nursing Education of the United States Public Health Service will publish material as regards costs relative to buildings of the Cadet Corps in Nursing which will be valuable.

Manitoba University in collaboration with the Manitoba Association of Registered Nurses offers qualifying examinations to student nurses at the end of their first year in the School of Nursing and at the end of their training for registration. The University assumes no responsibility for the inspection of schools or supervision of their curricula.

The Study of Hospitals in Manitoba 1941 report included reference to hospital schools of nursing and variation in education of student nurses and undesirable working hours and living conditions. It was suggested at that time that the University should assume responsibility for nursing education.

The training of nurses continues largely on a service rather than a professional basis. The hospital nursing schools, in return for student nurses undertaking much of the nursing required by the hospital, give them an opportunity for nursing training which generally varies in quality in proportion to the services required. Pedagogically this is, of course, unsound, and all education of professional nurses must eventually be placed upon the same pedagogical basis as training of other auxiliary medical workers, such as physiotherapists and occupational therapists, etc. The cost of bedside nursing to hospital administration will naturally be increased, but skilled bedside workers of the type being graduated now could be trained in a considerably shorter period.

The practical nurse is now being trained by the Provincial Department of Health and Public Welfare. Two points arise: *first*, as to whether the quarters of the present Central School are adequate, *second*, the present course trains only for institutional work. It is presumed that the report on the job analysis proposed below for the rural area at Dauphin would indicate the extent practical nurses may be utilized in the rural communities.

The question of using a generalized health and welfare worker was discussed at a conference with the two professions. It was decided that the first essential was a job analysis by a competent individual with background in both nursing and welfare to be undertaken in the Dauphin District. The steps required to train such a community worker would depend upon the results of this analysis. However, entirely apart from the question of a community worker, it was decided

> That the University should introduce social case work in the post-graduate training of public health nurses and preventive and social medicine in the training of social workers. It was suggested that the Deputy Minister should be responsible to take the steps required for preparation of the syllabi.

5. PUBLIC HEALTH ENGINEERS AND SANITARIANS.

The recommendations of "Local Health Units for the Nation" provide one public health engineer and one sanitarian for each 50,000 people. Consequently Manitoba's requirements obviously would not justify undertaking training of public health engineers. The Province is already training sanitarians. The Government-University Planning Committee should decide whether as a permanent policy it might not be done more effectively if undertaken in collaboration with one or more other Provinces.

6. PHARMACISTS.

The situation with respect to pharmacists was not surveyed. It is of interest, however, to note that during the school year 1945-46 there were 38 registered students in the last three years of the course (Twenty-nine in the second year—war). The American Council on Pharmaceutical Education for accreditation requires at least one full-time teacher of professional rank for each: Pharmacy, pharmaceutical chemistry, and *materia medica*. It appears, from the University Calendar, that Manitoba has one full-time professor.

7. AUXILIARY MEDICAL WORKERS.

Social workers and other auxiliary medical personnel discussed below, with the exception of X Ray technicians, receive their basic training in university disciplines outside of the Faculty of Medicine of the University of Manitoba. The general position relating to these workers may be considered at this point for the whole group. The medical teaching center should be responsible to provide acceptable practice facilities for each type of these auxiliary workers, regardless of whether the University of Manitoba is in a position to offer the required basic training in each field. Whether or not the Univer-

sity should undertake to provide such training is open to exploration by the Joint Government-University Planning Committee. An illustration occurs in respect to Home Economics giving basic training for dietitians and the School of Social Work, which should but does not train medical and psychiatric social workers. It happens that Manitoba has the strongest department of Home Economics of any of the western provinces, while its School of Social Work is still in a very embryonic stage. Unless the Province is prepared to support the latter on as high an academic level as the former, the question arises whether or not planning for basic training of medical social workers might not more effectively be undertaken in collaboration with a Provincial university already having a strong department, and, similarly, whether Manitoba might not undertake the basic training of dietitians for a Province whose department of Home Economics might either not exist or be in as weak a position as social work is at Manitoba. One realizes that provision of basic training in these several fields is not designed only for the specific auxiliary medical worker in question but also for other community needs. Thus examination of the case in question as to social science would also have to consider the probable Provincial demands for welfare workers, etc. However, whatever the decision reached in respect to basic training, it is essential that the medical teaching center does provide acceptable standards for the practice training required in these several auxiliary medical fields. The overall situation with respect to these auxiliary medical workers is summarized in the following Table

TABLE II TRAINING REQUIREMENTS (U S A) AUXILIARY MEDICAL WORKERS

Profession	Prerequisite	Training
1 Medical and Psychiatric Social Workers	4 years college	*1 academic year Graduate** 1 year practice**
2. Dietitians	4 years college**	1 year practice**
3 Occupational Therapists	1 year college	2 academic years Theoretical** 1 year Practice**
4 Physical Therapists	2 years college	1 year**
5 Medical Record Librarians	2 years college	1 year (50 weeks) Theoretical and Practice**
6 Laboratory Technicians	2 years college	1 year**
7 X-Ray Technicians	High School	2 years Theoretical and Practice**

1 MEDICAL AND PSYCHIATRIC SOCIAL WORKERS

The medical social workers' requirements for Manitoba in terms of the 72,000 in patients and 32,000 out patients reported for the year analyzed by the Report on Hospitals would require an eventual total of about 376 medical social workers, according to the standards established by the United States Medical Social Workers Association. Similarly, the approximately 3,500 admissions to Manitoba's institutions for the care of mentally diseased and mentally defective persons imply a minimum of 30 psychiatric social workers apart from the requirements of the four approved mobile clinics and any clinics which may be established in general hospitals.

The School of Social Work for the University does not as yet offer training for these two types of social workers, and the question has already been raised as to whether for the present it would be desirable to do so. However, both the Winnipeg General Hospital and its associated Psychiatric Ward, as well as the hospitals for Mental Diseases at Brandon and Selkirk, could readily be organized as accredited practice training institutions.

*Master's Degree.
**In accredited institution

2 DIETITIANS

Manitoba at the moment has 30 dietitians, 12 of whom are employed by the Veterans' Hospital Indications are that one dietitian is required for at least each 100 patients Thus Manitoba's 6,000-odd Provincial beds should be employing some 60 dietitians. The high level of the School of Home Economics has been noted However, the quarters occupied are inadequate It is remarkable that Manitoba, with such a good school, does not itself have a single accredited hospital to provide the required practice in dietetics. This defect should be immediately remedied

3 and 4. OCCUPATIONAL AND PHYSICAL THERAPISTS.

No definite overall figure has been reached yet as to standards for either occupational or physical therapists, but as indicated in Appendix IV, Manitoba is deficient in these two categories. However, one occupational and one physiotherapist is the standard set up for psychiatric hospitals for every 30 patients requiring such treatment The position with respect to Manitoba's 2,500 mental beds becomes obvious It is noted that the only training center in Canada for occupational therapists is Toronto, which is also one of the two training centers in Canada for physical therapy, the other being McGill Whether Manitoba should undertake training in these two fields is another question to be explored by the Joint Government University Planning Committee

5 MEDICAL RECORD LIBRARIANS.

While the hospital standards of the American College of Surgeons do not require the accredited medical record librarian for the small hospital under 50 beds which it does for the larger hospital, it does recommend that some person in the organization of the small hospital should be assigned the responsibility of such a library No data became available during the survey as to the number of trained medical record librarians in Manitoba Training in this field is another item to be reviewed by the Joint Government-University Planning Committee

6 and 7 LABORATORY AND X-RAY TECHNICIANS.

It is understood that one of the pending recommendations for action by the Board of Governors is the establishment of a course in training of both laboratory and X-Ray technicians, for both diploma and degree courses. It is recommended

That favorable consideration be given to this proposal

The latter would presumably absorb the two courses now being given in the Brandon Hospital for Mental Diseases, and which are not commented upon, in view of the Faculty of Medicine of the University's proposal Appendix I indicates the present position of Manitoba with respect to these two categories of auxiliary medical workers

IV GENERAL

EXTENSION HEALTH SERVICES—MENTAL, REHABILITATION, CHRONIC

There are three medical care fields which universally are lagging. These are Mental Health, Rehabilitation, and care of the Chronic Sick.

The Psychiatric Division has submitted a modest program for the period 1945-1951, providing for certain essential extensions and particularly establishing four mental health clinics. This program should be fulfilled as outlined. However, in addition it is recommended

That Manitoba undertake a mental health survey

It would be well in making recommendations for this report if the tentative organizational requirements for mental health published by the Ministry of Health of Great Britain were borne in mind A start has been made in rehabilitation under the psychiatric

field by the establishment of a home in Winnipeg for the training of high-grade mental defective girls in order that they may be equipped to work in homes in the community

No proposals as yet have been considered for a Rehabilitation program. There is no estimate as to the extent of disabled individuals in the Province. It has been estimated that up to 97% of all handicapped persons can be rehabilitated to the extent of gainful employment. In view of the dependence of many of these disabled individuals on public assistance, it is a matter of economic concern for Government to sponsor a rehabilitation program. Consequently it is recommended that consideration be given by the Department to establish a Rehabilitation Section under Hospitalization in the Bureau of Extension Health Services.

No knowledge is available of the extent of Chronic illness in the Province. The figures of the USPHS indicate that in the United States, exclusive of those confined to long-term care in mental or tuberculosis hospitals, there are 1½ million permanently disabled by some chronic disease, thus indicating its importance in any community. It is also known that a disproportionately large percentage of general hospital beds are unnecessarily occupied by long-term illness patients. Both from the standpoint of community medical care as well as hospital administration, this field is sufficiently important to justify due recognition. Consequently, it is recommended

That a designated section be established in Hospitalization under the Bureau of Extension Health Services.

V SUMMARY

The survey indicates that the following are the immediate steps which would accelerate implementation of the personnel needs of The Health Services Act.

1. The appointment of a Joint Government-University Planning Committee.

(2) Governmental assistance toward providing Dauphin with a certified radiologist and a pathologist.

(3) The undertaking in the immediate future by a competent individual of a job analysis, in the Dauphin area, of both nursing and welfare duties.

The first steps to inaugurate a long-term program would be completion of the following before the end of 1947:

(1) The appointment of a full-time Professor of Social and Preventive Medicine, and such necessary assistants as may be required, to serve concurrently as Assistant Dean, to be responsible for the training and research functions of the extramural constituent institutions and health centers associated with the medical teaching center, and to make necessary arrangements for various types of post-graduate and continuation training.

(2) The appointment of full-time heads for Medicine, Surgery, Obstetrics and Gynecology, and Roentgenology in the Faculty of Medicine to serve concurrently together with Pathology as consultants to the Bureau of Extension Health Services.

(3) Reorganization of the Dauphin and Brandon hospitals to the end of enabling them to comply with requirements for interne training and approved residencies in selected fields. The Joint Government-University Planning Committee should recommend the steps necessary for these two institutions to be associated with the Faculty of Medicine of the University as training institutions, more particularly with respect to internes and residents.

(4) Immediate inauguration of the Selkirk and Red River rural practice fields.

Implementation of the foregoing recommendations would lead to undertaking of the following long-term program:

(1) The planned provision for the personnel needs in all categories of The Health Services Act.

(2) Re-orientation of the different syllabi to train "basic" personnel in the fields of health service The scarcity of nurses, both institutional and community, gives priority to this field for consideration by the Joint Government-University Planning Committee with respect to each level required, i e ,

(a) university,
(b) the skilled bedside workers, and
(c) improvement in the teaching of practical nurses.

The question of the generalized health and welfare worker should also receive priority after the Dauphin job analysis is completed

CONCLUDING NOTE

The raporteurs would conclude on the note that the *'essential foundation of a comprehensive health service is a properly planned and carefully conducted medical teaching center* " It is reiterated that the required educational reforms must necessarily take time to mature and can only take place with proper co-operative efforts on the part of Government and University authorities.

Grateful appreciation is expressed of the courtesies extended during the visit to the group to Manitoba. Special thanks are recorded to Miss Evelyn J Mackay, from whom much valuable assistance was received.

APPENDIX I

DENTAL PERSONNEL—REQUIREMENTS

Mean Rate	Greater Winnipeg		Winnipeg Health Department		Balance of Province		Provincial Health and Welfare Department		Overall Manitoba
	Est 1945 pop. 320,000				Est 1945 pop. 480,000				
	Now Practising		Now Practising		Now Practising		Now Practising		
	Number	Population ratio	Number	Population ratio	Number	Population ratio	Number	Population ratio	
Dentists— 99 per 100,000 population*	199	62 2	1	31	55	13	2**	466	34
X-ray Technicians— 27 per 100,000 population	Four technicians qualified for certification. Approximately 115 out of 125 do routine work in connection with X-ray, such as developing, etc.				Estimated approximately 20 out of 25 dental assistants in this area do routine work in connection with X-ray, such as developing, etc.				19
Hygienists— 45 per 100,000 population	No legal standing to practise in Manitoba								
Laboratory Technicians— 18 per 100,000 population	These have been included in the calculation of the technicians								

*Lee Jones is the authority for the above dental requirements per 100,000 population, provided there is auxiliary staff

**1 for psychiatric patients and 1 for extension of health service program

APPENDIX II

MEDICAL SOCIAL PERSONNEL—REQUIREMENTS

1 per 200 general hospital admissions per annum, or 2,000 outpatients.*	**Manitoba** The available returns indicate the almost complete absence of certified medical social workers.

*United States Medical Social Workers' Standards

APPENDIX III

INSTITUTIONAL REQUIREMENTS

USPHS Standards	Greater Winnipeg Est. 1945 population 320,000		Balance of Province Est. 1945 population 450,000		Total	
	Number beds	Population ratio	Number beds	Population ratio	Beds	Population ratio
General—4.5 beds per 1,000 population	2,462	7 70	1,454	3 23	3,916	5 22
T.B.C. (S.D.R. 50)—1.2 beds per 1,000 population	490**	1 53	285	66	775	1 03
Mental—5 beds per 1,000 population					2,578	3 44
Chronic—2 bed per 1,000 population					712	95
The "General" beds are subdivided approximately		Percentage of general beds		Percentage of general beds		Percentage of general beds
Surgical—45% Medical—20%	1,315	53 4	737	50 7	2,052	52 4
Obstetrical—12%	280	11 87	257	17	537	13 7
Pediatric—4%	257	10 4	89	6 12	346	8 84
Miscellaneous—9%***	285	11 6	86	5 91	371	9 47
Bassinets—140% of "maternity beds"	325	116 0	285	110 9	610	113 6 of "maternity beds"

*The USPHS Standard of 12.7 beds per 1,000 is lower than the Australian Standard of 14.5, the Swedish at 15; but is approximately the same as the average of the British Regional Surveys

**In Sanatoria.

***Including 200 beds in Infectious Hospital, Winnipeg

APPENDIX IV

PERSONNEL REQUIREMENTS—MANITOBA HEALTH SERVICES

PSYCHIATRIC STANDARDS

The United States Public Health Services report of June 28, 1946, to be consulted for detailed psychiatric standards.

The over-all clinic requirements are:

	MANITOBA			
1 psychiatrist per 20 first-treatment cases per week	Psychopathic Ward 38 beds Psychiatrists—Wpg. Psy. Ward, 2½ City Health, 1½	Brandon 1,600 beds Brandon Specialists, 5 Asst M Ds. 2	Selkirk 960 beds Selkirk Specialists, 3 Jr Physician, 1	Manitoba School, Portage—500 beds Portage Specialist, 1 Asst Phy., 1

According to "Canada Mental Hospital Report," 1944, published in 1946, page 22. Manitoba had 429 first admissions, and 764 total admissions in 1944; and 1 doctor to every 177 patients (1946 would indicate an increase to 182 patients per doctor providing all beds occupied)

1 psychologist to—1 to 2 psychiatrists	1 attached to the Psychopathic Ward, Winnipeg, who at present is away on sick leave.
2 to 3 psychiatric workers to each psychiatrist	2—Psychopathic Ward, Winnipeg. (Services mostly confined to hospital, very little home investigation work done because of pressure of other duties). 2—Hospital for Mental Diseases Brandon. (These are Clinical nurses with their R N and Mental Hospital Diplomas They arrange for psychometric examinations and for rural child guidance clinics at country points)
1 clerical worker to each psychiatrist	Psychopathic Ward 1 stenographer 2 clerical assistants—2½ psychiatrists Brandon 6 clerk-stenographers. 1 statistical clerk—7 psychiatrists. Selkirk 3 clerk-stenographers. 1 statistical clerk—4 psychiatrists Portage la Prairie 2 clerk-stenographers. 1 statistical clerk—2 psychiatrists

NOTE—Above information obtained mostly from records of the Department of Health and Public Welfare, and through the Assistant Medical Superintendent of the Psychopathic Ward, Winnipeg

APPENDIX V

PERSONNEL REQUIREMENTS—MANITOBA HEALTH SERVICES

CLINICAL LABORATORIES

U.S.P.H.S. Standard

1 Pathologist per 300 beds
1 Technician per 100 beds
1 Interne per 100 beds

MANITOBA

Hospital	Bed Compliment	No. of Pathologists	No. of Technicians	No. of Others	No. of Internes
Grater Winnipeg					
Winnipeg General	610	2	7	2	2
St. Boniface	272	1	2	6	1
Children's	185	0	2	-	
Grace	349	2	1	1	
Misericordia	308	0	1		
Victoria	183	2	1		
St. Josephs	94	2	1		
Municipal	340	-		1	
Balance of Manitoba.					
Brandon	247	0	2		
Dauphin	117	(Being organized as a district under "The Health Services Act" organizational plan accepted by all officials involved)			
Gimli	48	-		1	
Morden	37	-		1	
Portage la Prairie	90		1		
Ste. Rose	50	-	-	1	
Selkirk	64	-		1	
St Anthonys, The Pas	98			1	

NOTE—Information obtained from records collected for Manitoba Hospital Survey, and from annual reports of general hospitals to the Department of Health and Public Welfare Survey 1942. Reports 1945.

APPENDIX VI

PERSONNEL REQUIREMENTS—MANITOBA HEALTH SERVICES

RADIOLOGY (LABORATORIES)

U.S.P.H.S. Standard	
1 Radiologist	per 300 beds
2 Technician	per 200 beds
4 Interns	per 300 beds
1 nurse	per 300 beds

MANITOBA

Hospital	Bed Complement	No. of Radiologists	No. of Technicians	No. of Others	No. of Interns
Greater Winnipeg					
Winnipeg General	610	2	4	5	1
St. Boniface	572	1	5	1	
Children's	135	3	1		
Grace	349	3	1	1	
Misericordia	309	3	1	2	
Victoria	133	3	1	1	
St. Joseph's	94	3	1	1	
Municipal	340		2		
Balance of Manitoba					
St. Mary's, Birtle	16	-		3	
Brandon	247	(Being organised as a district under "The Health Services Act" and required equipment and personnel supplied by Province)			
Dauphin	117	(Above note applicable here also)			
Gimli	48	-		1	
Morden	37			1	
Portage la Prairie	90			1	
Sacred Heart, Russell	65			1	
Steinbach	42		1		
Virden	30			1	
Winnipegosis	27			1	

NOTE—Information obtained from records collected for Manitoba Hospital Survey; and from annual reports of general hospitals to the Department of Health and Public Welfare. Survey: 1942. Reports 1945. All Laboratory information obtained rather sketchy.

PERSONNEL REQUIREMENTS—MANITOBA HEALTH SERVICES

MENTAL SERVICES—(The British Ministry of Health has tentatively adopted the following standards for mental services for 1,000,000 population

TENTATIVE BRITISH STANDARDS	MANITOBA
8 Mental Hospitals—units of 1,000 beds each	1 Psychopathic Ward, Winnipeg 38 beds 2 Mental Hospitals (1—Selkirk, 950 population; 1—Brandon, 1,600 population), 2,550 beds, or 1 bed for each 294.118 population as compared with 333.33 in British Standard.
2 units of 100 beds in 2 general hospitals	1 unit in Winnipeg, associated with Winnipeg General Hospital, with 38 beds, or 1 bed to every 19,737 of population as compared with 1 for 5,000 in British Standard. (Note—If there were another big city in the Province outside of Winnipeg it might be conceivable to have another psychopathic ward possibly located at Dauphin in the General Hospital or in the headquarters of the Local Health Unit However, with the Hospital for Mental Diseases at Brandon and the Clinics supervised from there, as well as the proposed plan to enlarge the present Psychopathic Ward in Winnipeg to a 60-bed ward, it is thought Manitoba's requirements will be amply met)
10 General Psychiatric Clinics in general hospitals	WINNIPEG Out-patient department, psychopathic ward—patients come by appointment all day each day excepting Sunday. Monday afternoons set aside for Child Guidance Clinics. Children's Aid Societies, Family Bureau and other social agencies bring children. From 3 to 6 cases per day, depending on amount of help available, are seen each day Usual plan is about 3 cases per psychiatrist The agency workers, teachers or others interested in cases examined come in about 4 30 and the cases are discussed with them in a round-table discussion.
4 Child Psychiatric Clinics 10 Child Guidance Centers	Child Guidance Clinics held at Winnipeg in the schools, psychopathic ward, and in Brandon in the schools—8 public and 2 high schools in Brandon—at the Hospital for Mental Diseases in Brandon and at points throughout the country at the request of the district. The Clinics from Brandon use hospital staff rather than work eg with social agency workers as is done in Winnipeg No formal clinics are held at either Selkirk or Portage la Prairie
50-bed hospital for unstable children	It is thought by psychiatric workers that a 50-bed hospital for unstable children would be a most desirable addition in Manitoba in order to carry out a better study and supervision of such children Nothing at present in operation Teaching of Medical Students—(Psychopathic Ward, General Hospital) The Dean of the Faculty of Medicine gives lectures to the medical students. The Psychopathic Ward gives all clinics work and students come four mornings per week, take histories and present them in conference, they go on wards during daytime, building their cases up. Conferences last 2½ hours when 2 cases are presented, including history, interview of patient, and discussion covering the underlying principles of the illness, diagnosis and prognosis of treatment
1 Child reception centre for child placement	In Manitoba there are two homes licensed by the Department of Health and Public Welfare for the care of subnormal children; one home holds a permit to care for 20 children and is situated in Greater Winnipeg, the other is situated in Virden—her home has been formally inspected and the Department is awaiting the recommendation of the Medical Officer of Health These children are placed by either the Division of Public Welfare of the Department, or through one of the Children's Aid Societies, of which there are six in Manitoba.

PERSONNEL REQUIREMENTS—MANITOBA HEALTH SERVICES
Concluded

1 Mental defective colonies, each 1,000	1 800-bed unit situated at Portage la Prairie, or 1 bed per 1,000 population as compared with 300 population in the Tentative Standard
Community care for 4,000 mentally subnormal	GREATER WINNIPEG 1. There are 14 classes of from 20 to 25 each for children who cannot benefit by the most bed program in regular classrooms. The children are segregated at [illegible] within their own area after careful, school and individual study. The I.Q. ranging from 50-75 depending on emotions and home structure. 2. Adjustment teacher work: For children who are under-functioning, slow or average learners, and who for some reason of personality adjustment have been unable to keep up with their grade. The children are assisted in the particular study they need help on, the adjustment teacher doing an individualized program with them, thus preventing the children to keep up with their proper age groups and avoid a backlog of retarded children. It is estimated 25 per cent of school population need some assistance under this plan. This estimate is arrived at through the clinical studies although no actual survey has been conducted in Greater Winnipeg. 3. Another program is carried out in conjunction with the Provincial Department of Education for the grossly defective children who are ineducable but trainable because there is no accommodation for them at Portage la Prairie or because in a number of cases the parents like to keep them and without some organized supervision these children would become a social menace. They usually graduate to the Manitoba School for Mental Defectives at Portage la Prairie at the age of 17 or 18 with the parents consent. This group is selected by results of psychological [illegible] and psychiatric interviews. All work of children and direction of teachers dealing with these groups of students is directed from the Central Child Guidance Clinic of the Winnipeg School Board. The clinics are financed by the City Health Department and Winnipeg School Board. The City Health Department supplies the services of psychiatrist, the School Board supplies the social workers, psychologist, speech therapist, and the personnel who are in charge of the adjustment program throughout the classes. The Provincial Department of Education takes care of: *Blind Persons*—Department of Education takes care of in Margaret Scott School of North Winnipeg and two in Brantford, Ontario. Non-resident children are placed in foster homes and the School Board of Winnipeg take them to and from home by bus. Children with poor eyesight are referred to Institute for Blind who take charge of seeing that any remedial measures are given such as examinations, glasses, operations, treatment, etc. The funds for this purpose are supplied by the Junior Red Cross. *Crippled Children*—Education where necessary conducted by Home Teachers. Shut-in children are supplied with correspondence courses for [illegible] grades by high [illegible] of the Province. 60 children enrolled in Winnipeg and 35 in the Greater Winnipeg. Funds are supplied by the Junior Red Cross when necessary for crippled children to receive necessary remedial care through the Children's Hospital. *Deaf Children*—Go to a residential school in Saskatoon, Saskatchewan. Enrollment 21. The deaf in Greater Winnipeg, enrollment approximately 60, teachers 3, have a class in the Wolseley School for day classes. The Manitoba Government is committed to accommodation for a residential day school for the deaf children in Manitoba as soon as building materials are available.

NOTE—Above material supplied

1. Division of Psychiatric Services, Department of Health and Public Welfare.
2. Bureau Public Health Nursing Service, Department of Health and Public Welfare.
3. Department of Education, Attendance Branch.
4. Child Guidance Clinics, Winnipeg School Board.